



PAYROLL DEDUCTION FORM

Please complete the information below. Use the Rate

Chart on this form to calculate the monthly premiums for your benefits.

Certificated Non-Certificated

Name: Mailing Address: Phone Number: Date of Birth: Social Security No: Male Female

Benefits Effective Date: Status Change Date: Full Time Hire Date: Job Title: Hours per Day Marital Status: Status Change Reason:

Designate your election for Medical, Dental and Vision below. Complete the information for your dependents on the next page. Dependents will not be enrolled unless this information is complete.

Medical, Vision, and Dental plan selection tables with monthly cost breakdowns for various coverage options.

MONTHLY EMPLOYEE COST FOR BENEFITS: \$

Employee Signature

Date

By signing this form, you are giving your employer permission to enroll you and any dependents on the coverage(s) elected above. You are also giving permission to deduct your paycheck for the amounts you have indicated. If this form is not completed, your enrollment on the benefits may be delayed. By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions: I agree to abide by all of the terms and conditions of the Plan. Plan Administrator may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.



Dependent Enrollment Information

Eligible dependents are your legal spouse and dependent children under age 26.

PLEASE USE LEGAL NAME AS IT APPEARS ON THEIR SOCIAL SECURITY CARD

Dependent(s):						
Name: First, initial, Last	Relationship (Spouse, Child, Stepchild, etc.)	Date of Birth	Gender	Social Security Number	Check benefits you are enrolling dependent on:	
			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
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			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
			<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

*You must select the correct coverage according to your election on page 1. For example, if you selected Family Coverage for Medical, you must check the Medical box for your Spouse and at least 1 child.